Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-10-3689-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: ZURICH AMERICAN INSURANCE CO Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: The requestor did not submit a position summary.

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Total Amount Sought $238.80

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Neither the carrier nor the pharmacy bill processing unit (Cypress Care) has received copies of the disputed billings."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
03/09/10, 03/24/10, 03/31/10	No EOBs submitted	Out-of-Pocket expense – Prescriptions	$238.80	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

According to the DWC-60 the requestor is listed as M.J. Pendleton, M.D. A phone call was made to Dr. Pendleton, M.D. at which time MFDR was notified that the requestor should have been the injured employee and that the form was incorrectly filled out. The doctor did not pay for the prescription medicines for the injured worker nor did Dr. Pendleton fill out the DWC-60.

Background

1. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §133.270 sets out the fee guidelines for the reimbursement of the out-of-pocket expenses incurred by the injured employee for their workers' compensation injury.

Issues

1. Did the requestor request reimbursement from the carrier?
2. Is the requestor entitled to reimbursement?

Findings

1. In accordance with Tex. Admin. Code §133.270 the injured employee is required to request reimbursement from the insurance carrier when the injured employee has paid for health care provided for a compensable injury. The respondent stated in their position summary that neither the insurance carrier nor the carrier's pharmacy agent has received a request for reimbursement from the requestor. In accordance with §133.307(c)(3)(D), the documentation submitted by the injured worker does not contain information which supports that the request for reimbursement was made to the carrier.
2. In accordance with §133.307(e)(3)(I) the Division has determined that the request for medical fee dispute resolution was not submitted in compliance with the provisions of the Labor Code and this chapter.
3. **Conclusion** For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.270, §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

Authorized Signature	Auditor III Medical Fee Dispute Resolution	August 18, 2010 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.